VIEWPOINT

# Bringing High-Value Care to the Inpatient Teaching Service

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**High-value care** is a strategic priority of major academic and medical organizations.[1] One of the greatest challenges training programs face is fostering practice patterns in young physicians that avoid tests and treatments of dubious value.

We now have high-quality curricula and elegant campaigns to help residents grapple with a previously neglected notion: that much of what we do in medicine is wasteful and sometimes harmful. This formal curriculum is essential to signal new values, start conversations, and redefine what a great physician does. But it is not enough. Medical students and residents are in a formative stage of their professional development where their attitudes and behaviors are shaped less by PowerPoint or posters and more by the actions of their supervisors and peers (the informal curriculum).[2]

For attending physicians who oversee residents' medical decision making on inpatient services, this forces an uncomfortable reality: residents cannot learn how to deliver cost-conscious medicine if it is not being practiced where they are being trained. Attending physicians have a responsibility not only to talk the talk but also to walk the walk if we hope to help create a generation of physicians who come to understand that the best doctors are often defined by restraint rather than action. Over the past year, I have tried to guide my inpatient teams to do less than we are normally inclined to do. It has been challenging at times, but the experience has convinced me that modeling high-value care is the most effective way to teach it.

## Choosing (Words) Wisely

I inform the senior residents that along with the standard instruction they expect from their ward attending physician, I will also be focusing on their ability to defer common practices—sometimes even "standards of care"—that are out of sync with evidence, discordant with the stewardship of health care resources, or conflict with patients' preferences.

I acknowledge the psychological forces that make it difficult to do less, including our discomfort with uncertainty and fear of making a mistake.[3,4] I divulge my discomfort in order to engage theirs: "Like you, I'm wondering about the small chance that our patient could become septic because we did not give him an antibiotic." But I also try to counter this unease by reminding them of risks, adding "but I'm also thinking about Mr Smith, where we likely overdiagnosed pneumonia, and by unnecessarily prescribing antibiotics caused his *Clostridium difficile* infection and his protracted hospital stay."

Our conversations around health care stewardship emphasize that there are finite resources and that doctors—not somebody else—have to make the tough decisions in allocating them. I try to catch myself in moments of exceptionalism such as "but our patients are sicker" or "those study results do not apply to our patient." At times such phrases are true, but if I find myself uttering them repeatedly, I recognize that I am essentially saying, "high-value care is a good idea…for somebody else's patients." Aphorisms like "when in doubt, rule it out" or "let's play it safe" have to be replaced with nuanced messages that praise the trainee for having thought about a rare or serious condition but also having exercised sound judgment in not pursuing it at an inappropriate time.[5] Finally, I have discarded one of the stock phrases for excessive testing: "this is a teaching hospital." I now think "this is a teaching hospital—so we are *not* doing an unindicated test or treatment." These expressions are hard to abandon because they seem so pro-patient and pro-education, but on closer inspection, they are exactly the opposite.

## Changing Our Practices

When I queried a resident about why she ordered antibiotics for a patient whose aspiration had been witnessed, she explained that she had seen it done regularly and that one attending physician had scolded her for not doing so. I supported her instinct to not practice in that way—and the patient, who mounted a short-lived fever and leukocytosis—did just fine without antibiotics.

We strive to reject the diagnosis of "bilateral lower extremity cellulitis," which is virtually synonymous with venous stasis, and see that erythema and pain improve with diuresis or elevation alone. One problem with this scenario is that utilization review asks "if the patient is not getting intravenous antibiotics, why is he in the hospital at all?"

Sometimes restraint is easy. When we commit to never prescribing routine prophylactic proton pump inhibitors[6] and see that no one on a general medical floor experiences gastric stress ulceration, practice patterns change quickly. Some change is harder: minimizing telemetry use has merits,[6] but it is easy for anyone (myself included) to imagine how a patient *might* have an arrhythmia. So we take that one in smaller steps (eg, do not admit patients with stable congestive heart failure or chronic obstructive pulmonary disease to telemetry beds). We avoid renal ultrasonography for acute kidney injury, leave asymptomatic bacteruria alone, and avoid head imaging for innocuous falls. A part of us *wants* to do the test or treatment "just to be sure," but when we sit tight, we see that all turns out well.

But it does not always. When a patient who was *not* tested or treated has an adverse outcome, the correla-

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tion is frequently turned into causation. Those moments fuel the availability heuristic—the tendency for a salient event to distort future probability judgments—and can make us reluctant to exhibit restraint again. I acknowledge our regret and then invite the resident to carefully examine whether our original decision had merit or had room for improvement. Modeling both positions is a critical attribute of the attending physician.

After a few forays into reducing testing and treatment, I have admired how residents will start embracing the philosophy. Change does not happen overnight, but early signs emerge, such as a computed tomographic scan that was forgone or one that was ordered after a very thoughtful analysis of the risks and benefits. As the residents pick up the mantra of doing less, they are sometimes faced with other physicians who prefer that they do more. I increasingly find myself contacting other attending physicians to advocate for doing less when our team perceives limited merit in doing more. We do not want to transfuse blood in this patient with coronary artery disease and a hemoglobin level of 7.5 g/dL. We do not want to give any medicine that is "low risk" when its absolute value, in fact, is zero. The specifics of these particular conversations are not critical—but the willingness to have them is.

## Conclusions

High-value care has been brought to our collective consciousness by the vision of leaders, political and economic forces, and a heightened professional duty to society. But it will never become a reality until it is embraced on the front lines by this generation of physicians and the next. Only a few medical educators are responsible for the formal curriculum, but *every* clinician is a leading figure in the informal curriculum that shapes norms and projects the values of our profession.

Teachers will catalyze this change among medical students and residents and fellow teachers on a case-by-case and conversation-by-conversation basis. Most physicians are more interested in improving outcomes for their patients than they are in safeguarding health care resources or in explicitly lowering the costs of care.[7] Fortunately, there is a growing list of evidence-based approaches that accomplish all of these goals. In having conversations about high-value care, I assess the situation and decide whether I will play the quality card, the safety card, or the cost card. When time is short and the message needs to be clear, however, I find that the explanation that encapsulates every aspect of high-value care is the simplest one: "it's good medicine."


### ARTICLE INFORMATION

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### REFERENCES


**1**. Smith CD; Alliance for Academic Internal Medicine–American College of Physicians High Value; Cost-Conscious Care Curriculum Development Committee. Teaching high-value, cost-conscious care to residents: the Alliance for Academic Internal Medicine–American College of Physicians Curriculum. *Ann Intern Med*. 2012;157(4):284-286.

**2**. Hafferty FW. Beyond curriculum reform: confronting medicine's hidden curriculum. *Acad Med*. 1998;73(4):403-407.

**3**. Lin GA, Dudley RA, Redberg RF. Cardiologists' use of percutaneous coronary interventions for stable coronary artery disease. *Arch Intern Med*. 2007;167(15):1604-1609.

**4**. LeFevre ML. Swimming upstream: doing less in health care is hard: comment on "No Papanicolaou tests in women younger than 21 years or after hysterectomy for benign disease" and "Cervical cancer screening intervals, 2006 to 2009." *JAMA Intern Med*. 2013;173(10):856-858.

**5**. Detsky AS, Verma AA. A new model for medical education: celebrating restraint. *JAMA*. 2012;308(13):1329-1330.

**6**. Society of Hospital Medicine. Adult medicine: choosing wisely. http://www.hospitalmedicine.org/AM/pdf/SHM-Adult_5things_List_Web.pdf. Accessed March 2, 2014.

**7**. Daly R. Putting physicians in the lead for cost containment. *Healthc Financ Manage*. 2013;67(12):52-59.